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CHILDREN IN THERAPY AS A SIGNAL FOR HELP FOR PARENTS.(U)
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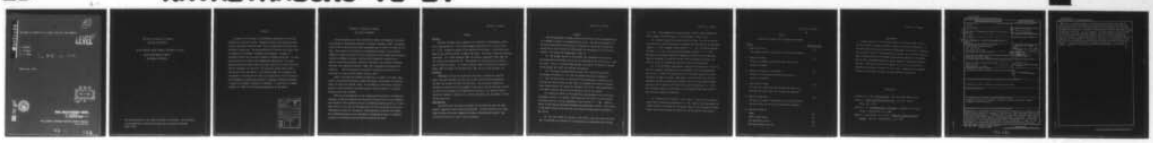

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CHILDREN IN THERAPY AS A SIGNAL FOR HELP FOR PARENTS

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Children in Therapy as a Signal for Help for Parents

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[1]The views presented in this paper are those of the author. No endorsement by the Department of the Navy has been given or should be inferred.

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Abstract

A sample of 114 children in 18 outpatient psychiatric clinics were studied over a one year period. Demographic data on the parents and the child, a behavioral complaint check list, and psychiatric decisions were collected in each case. The characteristics of the case which might lead to diagnosis and treatment strategies were examined. A number of characteristics of the case were related to treatment decisions: (1) very young children were usually not diagnosed as needing help, (2) young, educated mothers were more likely to bring a child to a clinic without the need for treatment for the child, (3) having the father return after a long absence often resulted in a child being brought for treatment, and (4) generally, children who are taken to a psychiatric clinic and who are not diagnosed are signals that parental or conjugal problems are present. If parents are treated, treatment is completed. If the child is treated, treatment is likely to be terminated prematurely by the parent.

Children in Therapy as a Signal for Help for Parents

Parental problems are often reflected in family relationships, including disturbances in the behavior patterns of children (Ackerman, 1970). Bringing a child to the clinician may be a more acceptable way for adults to reach out for help. When the child is offered as the presenting problem, the clinician's judgment is taxed to arrive at a clear definition of the problem and to develop a positive treatment strategy. When a child's behavioral dysfunction is evident, screening procedures, diagnostic processes, and treatment strategies have been fully developed (Kessler, 1966). But strategies and procedures to attend to familial problems are difficult to develop when the child is presented as a token patient (Sager & Kaplan, 1972).

When a child exhibits maladaptive behaviors in school or at home, intervention often mobilizes parental support and social reinforcement as effective modes for correction (Gordon, 1970). The strategy to intervene by involving parents is quite different from being aware of primary parental or conjugal problems which need treatment.

What are the consequences of not recognizing the primacy of the parental, conjugal, or personal complaint of the parent bringing the child for diagnosis and treatment? What characteristics of a presenting symptom pattern in a child might alert the clinician to the possibility of the child being offered as an introduction to help for the parent? These questions constitute the impetus for a detailed analysis of the rationale for screening children in outpatient clinics and intervening with the parent on parental problems.

Method

Subjects

Data was collected from a sample of 114 children in 18 outpatient clinics over a one year period. The children ranged in age from 2 to 17 (mean = 9.8, sd. = 3.3). Seventy-one percent of the population were males. The children were taken to the clinic by mother in 92% of the cases. The mother listed the following complaints: (1) school problems, 79%; (2) behavior problems at home, 20%, and (3) trouble with authorities, 1%. The problems of the children were rated by the clinician as follows: (1) school problems, 59%; (2) behavioral problems at homes, 18%; (3) parents not getting along, 12%, and (4) other problems, 11%.

Procedure

Demographic data on the parents and the child, a behavioral complaint check list, and the reason for the visit to the clinician were completed by the adult who brought the child to the clinic. The clinician recorded his impression of why the child was brought to the clinic; who had the idea to bring the child; the diagnoses; the disposition of the case, i.e., hospitalization, outpatient treatment, referral, or no further treatment; and the number of times the child was seen.

Data Analysis

Eta coefficients were used to examine the relationships among the demographic, behavioral, and clinical data gathered. Primary interest was in those cases in which no clinical diagnosis was made, reflecting some cases of the child being offered as a sign of family problems.

Results

The following major findings summarize the results from the examination of the strategy to refrain from diagnosing the child. The lack of diagnosis for the child coupled with the offering of treatment for the parent reflects the sensitivity of the clinician to looking past the presentation of the child as problem. The results are summarized in Table 1.

(1) The younger the child, the greater the likelihood that the child was presented as the patient but was not so diagnosed by the clinician (η = .43). The young child in a new marriage may bear the load of frustration of mother and may become the signal for problems and concerns.

(2) The young, educated mothers present their children as problems. The younger the mother(η = .31) and the greater the level of education (η = .20), the more likely is the child to be presented as a problem to the clinican, but the clinician is less likely to diagnose the child as a problem. These figures support the results of the age of the child. The young mother in a new family uses the child as an introduction to help for herself.

(3) Having the father in the home after long absences, such as military deployment, results in a greater likelihood that the child will be presented as a problem but will not be diagnosed by the clinician (η = .48). Father's return to the home and continued presence there generates friction. This results in the mother taking a child who may not manifest extreme behavior problems to the clinic.

(4) The fewer number of children in the family, the less likely the child who is presented as a problem will be diagnosed as a problem by the clinician

(η = .28). Young mothers with young children in small families appear to find it easier to see the focus of their problems in their child.

(5) Children presented as problems by the mother, but who are seen by psychiatrists as indicating parental problems, are described by the mother as "happy" (η = .24), "making friends easily" (η = .14), "not being dejected or sulky" (η = .19), and as not having "temper tantrums " (η = .19). Children who ultimately receive no diagnosis are seen in a very favorable light by the mother in spite of the fact that the mother has brought the child to the clinic obstensively because of the child's problems.

(6) If the clinician indicates no psychiatric diagnosis for the child, there is a greater likelihood that "no treatment" will be recommended for the child (η = .39); but further analysis of the data reveals that where outpatient treatment is given, those cases in which children are given no diagnosis and family problems are reported, more visits are made by mother and child than in cases of children with a specific diagnosis (η = .65). The treatment contract is more likely to be completed after more visits in which children receive no diagnosis.

(7) Completion of treatment is more likely in cases of "no diagnoses," where family problems are suspected (η = .49). Again, this data appears to reflect mother's involvement as the primary focus of the therapeutic process rather than the child being the reason for the therapeutic intervention.

Table 1

Dynamics of the Child as the Presenting Problem

Factor	eta coefficient
1. Age of the child.	.43
The younger child was more likely to receive no diagnosis.	
2. Age of the mother.	.31
Children of younger mothers were more likely to not receive a diagnosis.	
3. Amount of education of the mother.	.20
Children of more educated mothers were likely to receive no diagnosis.	
4. Time father at home.	.28
Children with fathers who had returned home after long absences were more likely not to receive a diagnosis.	
5. Number of dependents.	.28
The fewer the number of dependents in the child's family, the more likely the child was to receive no diagnosis.	
6. Child described as:	
Happy	.24
Makes friends easily	.14
Not dejected or sullen	.19
Not having temper tantrums	.19

Conclusions

Several features of the clinical pattern of children brought to the clinic by mothers indicate a potential problem in parental interaction. If the mother does not present a picture of disturbance in her child, is young, and has had the father in the home after an absence, the clinician should be alert to the possibility of the need to give direct services to the mother. When no clear childhood diagnosis is given, parental intervention might be required. Treating the child often results in failure of the parent to complete the therapeutic contract for the child. Recognizing the parental stresses is more likely to result in more complete intervention.

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Appearance of this material in the professional literature is in support of the Chief of Naval Material's program for Military-Civilian Technology Transfer and Cooperative Development. Military families experience stresses which result in a child being identified as a problem and taken to the doctor. Navy psychiatrists and the service families would benefit from guildelines to effective intervention. This study defined some of those guidelines. A sample of 114 children in 18 outpatient psychiatric clinics were studied over a one year

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